Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS5377HIC	A. BUILDING _____ B. WING _____	C 12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS CARE	8228 VIOLET MEADOW CRT LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	Initial Comments This Statement of Deficiencies was generated as a result of a State Licensure Complaint Investigation conducted in your facility from 10/20/10 to 12/9/10. This State Licensure survey was conducted by authority of NAC 449, Homes for Individual Residential Care, adopted by the State Board of Health on November 29, 1999. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. Complaint #NV00026696 was substantiated. See Tag H017. The following regulatory deficiencies were identified:	H 000		
H 017	Director Duties-Protective Supervision NAC 449.15523 Director: Duties. (NRS 449.249) The director of a home shall: 3. Ensure that the residents of the home: (b) Receive: (3) Protective supervision and adequate services to maintain and enhance their physical, mental and emotional well-being. This Regulation is not met as evidenced by: Based on record review, interview on from 10/20/10 to 12/9/10, the director failed to ensure that 1 of 1 residents received protective supervision and adequate services to maintain and enhance their physical, mental and emotional	H 017		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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H 017	Continued From page 1 well-being (Resident #1). Complaint #NV00026696.	H 017		